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Issue Date: 30 September 2003

CASE NO. 2003-LHC-0748

OWCP NO. 14-125524

In the Matter of

CLARENCE LaFOUNTAINÉ,
Claimant,

v.

FOSS MARITIME,
Self-Insured Employer.

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Before: Paul A. Mapes
Administrative Law Judge

DECISION AND ORDER MODIFYING PRIOR AWARD OF BENEFITS

This case arises from a claim under the Longshore and Harbor Workers' Compensation Act, as amended (hereinafter, the "Act" or the "Longshore Act"), 33 U.S.C. §901 *et seq.*, for various injuries that the claimant, Clarence LaFountainé, suffered on June 19, 1997 while working on board a tugboat that was undergoing repairs in a shipyard in Seattle, Washington. A trial on the merits of the claim was held in Seattle on November 16, 1999, and the following exhibits were admitted into evidence: Claimant's Exhibits (CX) 1-17 and Employer's Exhibits (EX) 1-17. In a Decision and Order served on February 1, 2000, it was determined that the claimant had a work-related left shoulder impairment and that the employer should pay him temporary total disability benefits until ordered otherwise.

In December of 2002, the employer filed a request seeking modification of the February 1, 2000 Decision and Order. CX 18 at 2. As a result, a second trial was held in Seattle on June 17, 2003. During the trial, testimony was received from two witnesses and the following new

exhibits were admitted into evidence: Claimant's Exhibits 18-24 and Employer's Exhibits 16-22. In addition, a pre-trial deposition of Dr. John P. Morris was admitted into evidence as Claimant's Exhibit 25 and a post-trial deposition of vocational consultant Merrill Cohen was received into evidence as Employer's Exhibit 23. Both parties filed post-trial briefs.

BACKGROUND

The claimant, Clarence LaFontaine, was born on December 26, 1947, and graduated from high school in 1966. Thereafter, he attended Evergreen State College for three years, but did not obtain a degree. CX 9 at 115, CX 16 at 162. In 1968, he received six weeks of vocational training in welding and in 1977 he began working as a shipyard welder. CX 16 at 162, EX 13 at 97. In 1990, the claimant started working as a boilermaker-leadman for Foss Maritime (hereinafter referred to as "Foss" or "the employer"). EX 13 at 97.

While employed as a boilermaker-lead man by Foss on June 19, 1997, the claimant slipped and fell after crawling through a lightering access hole on a tugboat undergoing repairs in a Seattle shipyard. EX 2 at 6. According to the claimant's testimony during the first trial, as he was attempting to stand upright after emerging from the hole, he lost his footing on a wet deck and grabbed the bottom part of the lightering hole, thereby jerking his left arm. Transcript of first trial (hereinafter cited as Tr. I) at 33-36, 54. Thereafter, the claimant finished his shift and did not report the incident until the next day. Tr. I at 36-37, EX 2 at 7. According to an injury report that was apparently filled out by the claimant on June 20, 1997, the only body parts injured during the accident were his left knee and right foot. EX 2 at 6.

On June 23, 1997, the claimant sought treatment from his family physician, Dr. John P. Morris. CX 3 at 72-73. Dr. Morris's report from that date notes that the claimant injured his left knee when he slipped and fell, but does not mention any other injury. *Id.* Dr. Morris again examined the claimant on June 27, and found "slightly warm" left knee patellar bursa, but normal ligaments and a full range of motion. CX 3 at 71. On July 2, 1997, the claimant was seen for a third time by Dr. Morris. This time, Dr. Morris' report stated that, in addition to injuring his left knee on June 19, the claimant had also apparently "injured his left arm" when he pulled himself through the lightering hole and worsened a pre-existing right foot condition while climbing a ladder. CX 3 at 70. Dr. Morris noted the claimant had some pain on resisted supination of the left arm that was consistent with a diagnosis of lateral epicondylitis. CX 3 at 70. He also found that the claimant had left lateral epicondyle tenderness but no swelling or loss of range of motion in his left elbow or wrist. *Id.* Dr. Morris's report also described the left knee injury as probably being a "contusion" and noted there was no history of previous left arm pain. *Id.*

During the months of July, August, and September of 1997, the claimant was seen by Dr. Morris on at least six occasions, but Dr. Morris's notes for that period do not mention any further left arm problems until September 16, 1997. CX 3 at 65-69. At that time, Dr. Morris commented that the claimant had "apparently" injured his left arm during the June 19 accident but added that he could not recall having previously treated the arm. CX 3 at 65. He also noted that the claimant had reported experiencing pain on the lateral side of his left elbow which had

been exacerbated by wall pushups recommended for treatment of his foot problem. *Id.* Dr. Morris further reported that his physical examination of the claimant's left arm found tenderness over the lateral epicondyle and elicited complaints of pain on resisted supination. Dr. Morris added that the complaints of pain on supination were consistent with the diagnosis of lateral epicondylitis. CX 3 at 65.

On September 29, 1997, Dr. Morris again examined the claimant. CX 3 at 64. At that time, he noted that the claimant was still limping and still had tenderness in his right foot and left elbow. *Id.* Dr. Morris concluded that he did not feel that the claimant "would be able to return to his former job, which included climbing up and down ladders and crawling from one tank in the ship to the next, for some time, at least six months." CX 3 at 64.

Dr. Morris next examined the claimant on December 8, 1997, at which time the claimant complained of continued pain in his left knee, right foot, and left elbow and new pain in his left shoulder. CX 3 at 63. Dr. Morris found tenderness in the medial side of the claimant's knee, but concluded that the ligaments were intact and the range of motion was normal. When he examined the claimant's left arm he found no tenderness in the lateral epicondyle and no pain with resisted supination. He did, however, find the range of motion in the claimant's left shoulder to be limited to about 90 degrees of abduction. Dr. Morris commented that the pain in the claimant's left shoulder might be attributable to "nonuse of his arm" and recommended that the claimant undergo an "IME" to "look at his long term prognosis." CX 3 at 63.

Accordingly, the employer's claims administrator arranged to have the claimant evaluated by Dr. Kevin R. McNamara, an orthopedic surgeon. CX 10 at 122. When Dr. McNamara examined the claimant on January 14, 1998, the claimant complained of continuing discomfort and pain in his right foot, left knee, and left elbow. Dr. McNamara's examination of the claimant's left arm revealed no crepitus, swelling, or erythema in the elbow, but did elicit reports of tenderness about the claimant's lateral epicondyle. *Id.* at 128. The examination of the claimant's left knee found some mild constant patellofemoral crepitus and tenderness along the medial patellar facet. Dr. McNamara diagnosed the claimant's complaints as lateral epicondylitis of the left elbow, which he opined was related to industrial exposure on a "more probable than not" basis, and post-traumatic chondromalacia patella of the left knee. *Id.* at 130. He ordered x-rays of the claimant's elbow and recommended that it be treated with physical therapy and medication. Six days later, Dr. Sherrie Chatzkel interpreted x-rays of the claimant's left elbow as being normal. *Id.* at 134.

On February 4, 1998, Dr. Morris again saw the claimant and noted that he "continues to have pain in his right arm and difficulty lifting." CX 3 at 61. Dr. Morris found tenderness over the lateral epicondyle, but no muscle wasting. He also noted that a neurological examination of "the upper extremity" was normal.¹ CX 3 at 61. On March 2, 1998, Dr. Morris examined the

¹ Although Dr. Morris's report refers to symptoms in both the claimant's arms, the report does not state which upper extremity was given the neurological examination. However, it appears more likely than not that the statement indicating that the claimant complained of "right" arm pain was mistaken and that Dr. Morris actually meant to refer to left arm pain.

claimant's left arm and found a full range of motion as well as an absence of tenderness over the left lateral epicondyle. He thus described the results of the exam as being "pretty normal." CX 3 at 60.

On April 20, 1998, Dr. Morris noted that the claimant was "now starting to develop some pain in his left shoulder and an inability to abduct his left shoulder over 90 degrees." CX 3 at 58. He also reviewed Dr. McNamara's report and agreed with his diagnosis of left arm lateral epicondylitis and post-traumatic chondromalacia patella in the left knee. He also agreed that both conditions were related to the claimant's work injury. Dr. Morris further concluded that the claimant's left arm condition was not yet "fixed" and he therefore declined to set forth any job limitations. In addition, Dr. Morris also indicated that the claimant was being referred to Dr. David M. Witham for evaluation of the left elbow and left shoulder conditions. *Id.*

On April 23, 1998, Dr. Witham examined the claimant and sent Dr. Morris a letter in which he reported that he found the claimant's neck range of motion to be full and the strength in his left arm to be excellent except when the arm was abducted over 90 degrees, when there was weakness attributable to discomfort. CX 7 at 91. Dr. Witham also noted that there was tenderness over the claimant's superoanterior rotator cuff but a full passive range of motion in the shoulder. He characterized x-rays of the left shoulder as being normal and indicated that it was his "impression" that the claimant's condition consisted of left shoulder rotator cuff tendinitis, impingement syndrome, subacromial bursitis, and left lateralepicondylitis. CX 7 at 91. Dr. Witham recommended physical therapy and various injections for the left shoulder and elbow. *Id.*

On June 4, 1998, Dr. Witham again wrote to Dr. Morris concerning the treatment of the claimant's left arm complaints. CX 7 at 93. Dr. Witham noted that the claimant reported feeling stronger after completing a course of physical therapy but continued to complain of pain that was severe enough to prevent him from returning to work. CX 7 at 93. Dr. Witham also indicated that his most recent examination had revealed "a painful arc of motion from 70 to 110 degrees," but showed no strength reduction with the arm in an adducted position. Dr. Witham indicated that it was his "assessment" that the claimant's condition consisted of "chronic left shoulder tendinitis and left lateral epicondylitis." CX 7 at 93. He further concluded that surgery would not be appropriate for these conditions and recommended that they be treated conservatively. Dr. Witham also opined that instead of keeping the claimant off work, efforts should be made to move him toward vocational rehabilitation or a job he feels capable of doing. CX 7 at 93.

About a week later, Dr. Morris examined the claimant and noted that he could not see any changes in the claimant's condition over the last several months. He therefore opined that the claimant's condition was "fixed." CX 3 at 54. He added that, because of the claimant's ongoing knee and arm problems, it did not look like the claimant would be returning to his "former type of employment." *Id.* In his notes of a July 8, 1998 examination, Dr. Morris repeated his conclusion that the claimant's condition had become fixed and stable. CX 3 at 52.

On July 14 and 15, 1998, the claimant underwent a "performance-based functional capacities evaluation" under the direction of Robert Henderson at HealthSouth Industrial Rehabilitation Clinic in Seattle. CX 8. According to the clinic's report, the claimant was asked

to respond to a series of verbal and written questions concerning his subjective perception of his physical limitations and given a musculoskeletal evaluation by a physical therapist. In addition, the claimant was also given several physical performance tests, including tests designed to measure his hand dexterity, whole body range of motion, lifting ability, and grip strength. The clinic's report indicated that the claimant considered himself able to do very few tasks without discomfort and had varying degrees of pain in his neck, left arm, left knee, and right foot. The physical therapist's evaluation noted that the claimant had "consistent symptoms of lateral epicondylitis" of the left forearm and showed signs of "calcific change" in his left clavicle. CX 8 at 99. The claimant scored no higher than the seventh percentile on a pegboard hand dexterity test and no higher than the 40th percentile on a hand tool dexterity test. The report's summary listed the claimant's primary limiting factors as: "inability to squat/kneel to do activities below waist level, and inability to get upper extremity above shoulder height for bilateral activities above shoulder level." *Id.* at 94. The summary also concluded that the claimant "could consistently function at the sedentary level on a full-time basis," but might need to participate in a work conditioning program to build up a higher level of fitness necessary for retraining.

Sometime thereafter, the claimant began participating in a work hardening program, but according to notes made by Dr. Morris in September of 1998, progress was very slow and he was discharged from the program without showing "much improvement." CX 3 at 47, 48. On October 5, 1998, Dr. Morris sent Foss a letter in which he reported that although the claimant had completed the working hardening program, his physical functioning had not changed significantly from the findings set forth in the July 1998 report of the HealthSouth Industrial Rehabilitation Clinic. CX 3 at 46. Dr. Morris further noted that at that time the claimant was capable of performing only sedentary work. *Id.*

In November of 1998, the claimant was referred by Dr. Morris to United Backcare where he was evaluated by a physician, physical therapist, vocational specialist, and psychologist. CX 9. The physician who examined the claimant, Dr. Tom Feher, characterized the claimant's account of his medical history as being "circuitous and frequently vague." Dr. Feher further indicated that when he examined the claimant's neck, the neck was resistant to passive movement and its movement caused the claimant to complain of pain which was localized on the left. CX 9 at 108. Dr. Feher also noted that the claimant would not flex or abduct his left arm more than 30 to 40 degrees at the shoulder and observed that there was crepitus in both his knees but no evidence of instability. Dr. Feher's diagnosis was lateral epicondylitis of the left elbow, post-traumatic condromalacia of the left knee, and recurrent plantar fasciitis, all "by history." CX 9 at 109. The psychologist who examined the claimant, Dr. Michael D. Harris, reported that the claimant's answers to questions on an MMPI-2 exam were "consistent with both pain patient characteristics and mild depression." CX 9 at 120. Dr. Harris also noted that the validity scale on the MMPI-2 indicated that the claimant was "generally candid in the way he presented himself on the test." Dr. Harris further reported that the results of a Waddell Fear-Avoidance Behavior Questionnaire indicated that fear of increased symptoms and re-injury were playing a substantial role in the claimant's current disability behaviors. CX 9 at 120. In a cover letter summarizing the results of the evaluation, Dr. Feher recommended that the claimant be admitted to United Backcare's "Return to Work-Pain Management Program." CX 9 at 106.

On December 29, 1998, the claimant was again examined by Dr. Morris, who reported that at that time the claimant's "most troublesome symptom" was left elbow and shoulder pain. CX 3 at 39. Dr. Morris commented that he believed the shoulder pain was secondary to the pain and lack of range of motion in the elbow and added that the claimant's symptoms had worsened since he stopped going to physical therapy. *Id.* Dr. Morris also reported that the claimant "is now definitely losing muscle mass" in his left arm and indicated that the circumference of the claimant's left forearm was two centimeters smaller than the circumference of his right arm. *Id.* In treatment notes dated January 25, 1999, Dr. Morris reported that the claimant had returned to physical therapy and commented that an unnamed physical therapist had also noted "wasting" in the claimant's left forearm. CX 3 at 37. In treatment notes dated February 22, 1999, Dr. Morris indicated that the results of his examination of the claimant's left knee were "normal" but that there was still a one centimeter difference in the circumferences of the claimant's forearms. CX 3 at 36.

At some unspecified date in the Spring of 1999, Dr. Morris referred the claimant to Dr. Deborah Amos, a physiatrist. CX 2 at 33. The claimant was first examined by Dr. Amos on May 4, 1999. CX 17 at 5. During the examination, the claimant complained of dull aching pain in his neck and left trapezius as well as sharp, electric pains in his left forearm that were worse when reaching or with neck movement. CX 2 at 29-30. The claimant also asserted that he was generally tired and had trouble concentrating. Dr. Amos's physical examination indicated that there was muscle "atrophy" in the left shoulder deltoid muscle, a positive Hoffman's test on the left, and active left shoulder abduction that was limited to approximately 90 degrees. CX 2 at 29-31. Among other things, Dr. Amos recommended that the claimant have an EMG performed to detect any cervical radiculopathy, neck x-rays, and a cervical MRI. CX 2 at 32.

As suggested by Dr. Amos, on May 7, 1999, Dr. Raymond W. Valpey performed electrodiagnostic studies of the claimant's left arm. EX 10. According to Dr. Valpey's report, the results of these tests were all "normal" and showed no electrodiagnostic evidence of motor radiculopathy, radial neuropathy, or median neuropathy. *Id.*

On May 10, 1999, Dr. Morris sent Foss a letter in which he reported that the claimant's condition was worsening and requested that job searches and job training be held in abeyance. CX 3 at 34. He also informed Foss that Dr. Amos would be taking over responsibility for providing care to the claimant.

On June 1, 1999, Dr. Amos again examined the claimant and found that abduction and external rotation were decreased when his left shoulder was examined for passive range of motion. CX 2 at 27. Dr. Amos also noted that crepitus was "palpable" in the claimant's left shoulder and that sensation was "subjectively decreased" throughout much of the claimant's left arm. CX 2 at 27-28. On June 1, 1999, Merrill A. Cohen, a vocational rehabilitation counselor retained by Foss, submitted a report in which she concluded, on the basis of the physical restrictions described in the July 1998 "Performance Based Functional Capacities Evaluation," that the claimant was incapable of returning to work as a boilermaker-leadman. EX 13. However, Ms. Cohen also concluded that the claimant was capable of performing alternative types of work and specifically identified eight such jobs that she had found to be available to job seekers in the Seattle area during the period between April 2 and 28, 1999. *Id.* Among these

alternative jobs were dispatcher, customer service representative, telemarketer, appointment setter, bench assembler, and parking cashier positions. *Id.* The wages for these jobs ranged from \$6.00 to \$11.00 per hour. *Id.* Attachments to the report indicate that Ms. Cohen had sent the claimant information about these job openings as soon as she became aware of them. *Id.*

On June 7, 1999, Foss determined that the claimant had the ability to perform one of the jobs identified in Ms. Cohen's labor market survey and therefore reduced his weekly compensation payments from \$468.90 to \$202.23. CX 1 at 5-7.

On June 30, 1999, Foss had the claimant evaluated by Dr. Richard G. McCollum, a board-certified orthopedic surgeon. CX 11 at 136, EX 12. In his report to the employer's counsel, Dr. McCollum summarized many of the claimant's treatment records and set forth the results of his own physical examination of the claimant. In describing the results of the physical examination, Dr. McCollum noted that the claimant reported decreased sensation to pinpricks in various areas of his left hand and arm, but added that any sensory deficit "was in a nondermatomal pattern." *Id.* He also found shoulder flexion and abduction to be greater on the right than on the left, but indicated that he observed no atrophy, tenderness, swelling, redness, or crepitus in the left shoulder. *Id.* The report further indicated that the circumference of the claimant's right forearm was two centimeters greater than the circumference of his left forearm and that the claimant's right upper arm circumference was one centimeter larger than his left upper arm circumference. CX 11 at 141. In concluding the report, Dr. McCollum commented that the claimant did not provide maximum cooperation in the range of motion testing and noted that the claimant did not move his right shoulder "very well," even though there was no alleged problem with that shoulder. Dr. McCollum also concluded that there were "no positive objective findings" that would justify any further diagnostic or therapeutic measures and asserted that he didn't "see any evidence" that the claimant had either a cervical or shoulder condition related to his June 1997 injury. CX 11 at 142. He also opined that he did not see any reason why the claimant could not return to the same type of work he was performing at the time of that injury. CX 11 at 142. Finally, Dr. McCollum opined that the combination of the claimant's symptoms and "bizarre physical findings" did not support a clinical diagnosis of on-going musculoskeletal problems. CX 11 at 143.

On July 1, 1999, Dr. Amos completed a Department of Labor work capacity evaluation form in which she indicated that in her opinion the claimant was at that time precluded from performing overhead work, repetitive hand movements, prolonged wrist flexion and extension, lifting more than 20 pounds, prolonged grasping, or tasks requiring more than occasional kneeling, standing or bending. CX 16 at 170-71. She further opined that any return to work should begin gradually and should not be full time until after the claimant had worked part-time for at least a month.

On July 12, 1999, the claimant was examined by Dr. Michael E. Blatner, a hand surgeon, for evaluation of the complaints of pain in his forearm. CX 17 at 11. In his report to Dr. Amos, Dr. Blatner opined that the claimant's left arm was "remarkable for a decrease in the muscle mass of the forearm" which appeared to Dr. Blatner to be "more of a generalized wasting" than a loss in any specific muscle or muscle group. CX 5 at 78. Dr. Blatner's report further noted that the claimant's left shoulder "appears smaller in muscle mass" than the right shoulder, but

commented the difference might be due to the claimant's posture. *Id.* The report also indicated that the claimant described palpation of his lateral epicondyle as being "extremely painful" and complained of pain in the left side of his neck. CX 5 at 78-79. Dr. Blatner's "impression" of the claimant's condition was left lateral epicondylitis, altered radial sensory nerve distribution of the left arm and forearm, and left hand, forearm, arm, and neck pain of uncertain etiology. In concluding his report, Dr. Blatner speculated that the claimant's symptoms might be attributable to an injury "at the level of the brachial plexus" and commented that there may have been "a stretch-traction injury that occurred during the June 1997 accident." CX 5 at 79.

On July 15, 1999, Dr. Amos again examined the claimant. She noted that the claimant was still reporting left knee and left arm pain and commented that he appeared to be experiencing some impingement in his left shoulder. She also observed that the claimant had symptoms of possible depression and therefore decided to refer him to a psychologist for evaluation. Dr. Amos further noted that the claimant's condition was not fixed and stable and that she had not yet released him to return to work. At the report's conclusion, she indicated that she was continuing to "strongly" recommend that the claimant be given a MRI scan of his neck and left shoulder. CX 2 at 20-22.

On July 19, 1999, the claimant was evaluated by physical therapist Michael Egbert at the request of Dr. Amos. Mr. Egbert concluded that it was clear the claimant was in need of a physical therapy "on a comprehensive level from nearly head to toe." CX 12 at 146.

On July 26, 1999, the claimant was again seen by Dr. Blatner. In his report of that date, Dr. Blatner agreed with Dr. Amos that the claimant's left arm symptoms might possibly be attributable to a brachial plexus injury and that such an injury might have been caused by a traumatic stretching or by a "direct injury." CX 5 at 80. Dr. Blatner also indicated that there was nothing in the claimant's left hand or forearm that he could treat further. He therefore recommended that any additional treatment be provided by Dr. Amos. *Id.*

On July 28, 1999, Dr. Amos again examined the claimant. She noted in her records that there was "muscle atrophy" around the claimant's left shoulder girdle and throughout much of his left arm and forearm. In addition, she observed that the active range of motion in the claimant's left shoulder was impinged, but his passive range of motion was unremarkable. CX 2 at 19-20.

On August 20, 1999, a MRI scan of the claimant's cervical spine was performed by Dr. Shane Macaulay. CX 2 at 17-18. According to Dr. Macaulay's report, the scan showed a straightening of the normal cervical lordosis, some multilevel loss of vertebral body height that was "most likely developmental or degenerative," some small disc protrusions at C4-5 and C6-7, and a small to moderate protrusion at C5-6 which indented the spinal cord.

On August 26, 1999, the claimant visited Dr. Amos and told her that his physical therapy sessions had been a "torture chamber" which had caused his pain to "skyrocket." CX 2 at 13. Dr. Amos noted that the MRI of the claimant's cervical spine showed disc protrusions, but commented that in her opinion the protrusions were "quite small." She also performed a physical examination and noted that there still appeared to be "some atrophy" around the

claimant's left shoulder. In addition, she performed various EMG studies which she found to show "[n]o electrodiagnostic evidence of left radiculopathy, ulnar neuropathy, median neuropathy, carpal tunnel syndrome, or thoracic outlet syndrome." *Id.* at 16.

On August 31, 1999, Dr. Phillip Knowles, a psychologist, reported to Dr. Amos that he had met with the claimant on three occasions and given him various psychological tests. CX 17 at 13. Among other things, Dr. Knowles indicated that on a psychological test called the Symptom Checklist 90 (SCL-90) the claimant "scored essentially off of the scale on somatization, obsessive-compulsiveness and depression." CX 4 at 75. Likewise, Dr. Knowles reported that the claimant's answers to questions asked on the Millon Clinical Multiaxial Inventory-II (MCMI-II) indicated that the claimant was "experiencing a moderately severe mental disorder" with a "strong somatic component." It was further noted that although these results appeared to conflict with the claimant's minimal "depression and anxiety scores" and average "somatization scores" on the Pain Patient Profile (P-3), the conflict could be due to the fact that these tests "are normed on quite different populations." CX 4 at 75. Dr. Knowles concluded that the claimant "could benefit from regular psychotherapy visits." CX 4 at 76.

On September 23, 1999, Dr. Amos performed another physical examination and noted continued muscle atrophy around the claimant's left shoulder. CX 2 at 11. In addition, she also observed "clicking" in the claimant's left shoulder and left-sided "scapular winging," that was not apparent on the right side. She recommended that the claimant resume physical therapy and begin receiving psychotherapy from Dr. Knowles, but noted that the "insurance company" was refusing to pay for either type of treatment. CX 2 at 11-12. On this same day, Dr. Amos sent the claimant's attorney a letter in which she disputed the conclusions set forth in Dr. McCollum's report of June 30, 1999. CX 2 at 9, 10. Among other things, she asserted that Dr. McCollum's description of the claimant's injury failed to acknowledge that the claimant had apparently grabbed at an opening with his left arm and contended that this type of occurrence "could have caused a traction-type injury to the left arm and shoulder, possibly a brachioplexopathy." CX 2 at 9. Dr. Amos also disagreed with Dr. McCollum's conclusion that there was no muscle atrophy in the claimant's left shoulder and asserted that, contrary to Dr. McCollum's finding, she had "consistently seen muscle atrophy, as well as winging of the left shoulder." *Id.* She also disagreed with Dr. McCollum's opinion that the claimant was ready to return to work.

On September 29, 1999, the claimant was seen at the request of Dr. Amos by Dr. Kim B. Wright, a neurosurgeon. CX 15 at 159a. Dr. Amos referred the claimant to Dr. Wright because she thought the claimant's pain and atrophy could be caused by an injury to the nerves in his neck. CX 17 at 13-14. Dr. Wright's examination found that the claimant had a limited range of motion in his neck attributable to pain complaints; that both his neck and left shoulder were tender to palpitation; that he demonstrated marked guarding and limitation of motion in his left shoulder, especially in abduction; and that he was tender over the lateral epicondyle of the left elbow. Dr. Wright reported that these physical findings might be symptomatic of some type of frozen shoulder problem or impingement within the shoulder and therefore suggested that the claimant should be seen by two other physicians: Dr. Pierce Scranton, an orthopedic surgeon, and Peter Mohai, a rheumatologist. CX 15 at 159b, CX 17 at 14. However, Dr. Wright also noted that the MRI of the claimant's cervical spine was "rather unremarkable" and that the EMG testing of the claimant's nerve functioning did "not demonstrate sign of a brachial plexopathy,

stretch injury, or entrapment neuropathy.” CX 15 at 159b. Dr. Wright thus concluded that the claimant was not then a candidate for neurosurgery.

As previously noted, a Decision and Order was issued in this proceeding on February 1, 2000. Among other things, that decision determined that (1) the claimant did not have any permanent work-related left knee impairment, (2) that the claimant did have a work-related left shoulder impairment, (3) that the left shoulder impairment had not yet reached the point of maximum medical improvement, (4) that the claimant’s average weekly wage at the time of his left shoulder injury was \$1,126.22, (5) that the employer was required to provide the medical care recommended by the claimant’s treating physician, Dr. Deborah Amos, including an MRI scan of the claimant’s left shoulder, and (6) that until ordered otherwise, the employer must pay the claimant total temporary disability benefits at a compensation rate of \$750.81 per week.

The claimant was again seen by Dr. Amos on February 8, 2000. Dr. Amos noted that a decision favorable to the claimant had been issued in this proceeding and that the employer had been ordered to pay for the medical treatment she had recommended. CX 21 at 82. Dr. Amos determined that the claimant should resume his treatment from Dr. Knowles, return to Dr. Blatner for further treatment of his neck, shoulder and left-side epicondylitis, and increase his physical therapy to three times a week. CX 21 at 83. In addition, Dr. Amos secured the claimant’s consent to begin replacing his usual pain medications with a “blinded pain cocktail.” CX 21 at 83. As part of the blinded pain cocktail arrangement, the claimant agreed to keep all medical appointments and to not get narcotic pain medications from anyone other than Dr. Amos. CX 21 at 83.

On March 7, 2000, the claimant saw Dr. Amos for a routine, follow-up visit. CX 21 at 80. The claimant told Dr. Amos that he had pain in his neck, left shoulder, left forearm, and back. He also reported that he was having difficulty sleeping and Dr. Amos noted that the claimant had a “probable depression.”

On or about March 22, 2000, the claimant was examined by Dr. Pierce E. Scranton, Jr., an orthopedic surgeon recommended by Dr. Wright. CX 22 at 86-87. In a subsequent letter to Dr. Amos, Dr. Scranton noted that it was difficult to examine the claimant and that his examination revealed “a number of Waddell’s signs.” Because of these signs, he noted, he “could not get an accurate assessment” of the claimant’s rotator cuff function. Dr. Scranton further noted that although there was no neurological condition that would warrant any form of surgery, the claimant should undergo a MRI scan of his left shoulder to determine if he had a rotator cuff tear.

On April 13, 2000, the claimant underwent the left shoulder MRI scan recommended by Dr. Scranton. CX 22 at 88-90. According to the radiologist’s report, the scan showed a “full thickness rotator cuff tear.” CX 22 at 88.

On May 2, 2000, Dr. Scranton reported to Dr. Amos that the rotator cuff tear shown on the MRI scan warranted surgery and indicated that post-surgery rehabilitation would probably take as long as three months. CX 22 at 91. Dr. Scranton also indicated that it was probable that

the claimant also needed surgery to treat the epicondylitis in his left elbow, but that it would be inadvisable to perform such surgery at the same time as the rotator cuff surgery. CX 22 at 91.

On May 8, 2000, the claimant was again seen by Dr. Amos. CX 21 at 76. She reported that Dr. Scranton would be performing surgery to repair the claimant's torn rotator cuff on June 5, 2000. While being examined by Dr. Amos the claimant complained that he continued to have neck and back pain, as well as some pain in his left forearm.

On June 5, 2000, Dr. Scranton performed surgery to repair the tear in the claimant's left rotator cuff. CX 22 at 92.

On July 17, 2000, the claimant saw Dr. Amos for a routine, follow-up visit. CX 21 at 72. Dr. Amos reported that the physical therapy for the claimant's left shoulder appeared to be going well, but that the claimant had complaints of neck and back pain.

On August 7, 2000, Dr. Scranton sent a report to Dr. Amos in which he indicated that he had "tested the integrity" of the rotator cuff repair surgery and had found that the repair appeared to be "completely intact." CX 22 at 93. However, he indicated, the claimant was "exhibiting more and more functional behavior" and these functional complaints had made him "pessimistic" about the value of any further orthopedic treatment. Dr. Scranton also noted that he doubted the veracity of the claimant's assertion that his left shoulder was in worse condition than it was before the surgery. In concluding his report, Dr. Scranton suggested to Dr. Amos that she consider "some form of psychiatric evaluation" for the claimant.

On August 8, 2000, the claimant saw Dr. Amos and complained that he had "agonizing and unbearable" neck pain. CX 21 at 68. When Dr. Amos examined his neck, she reported that his range of motion was less than it had been when she was taking the claimant's history and "relatively unremarkable."

On October 16, 2000, Dr. Amos told the claimant that it was her recommendation that he participate in a formal pain program and later that same day decided to refer the claimant to a pain program at the Virginia Mason Medical Center. CX 21 at 65, 67.

Sometime in 2001, Dr. Amos decided to geographically re-locate her medical practice and began to transfer her medical practice to another board-certified specialist in physical medicine and rehabilitation, Dr. Aleksandra M. Zietak.² While in the process of accomplishing this transfer, Dr. Amos prepared a February 6, 2001 document entitled "Closing Rating Examination." CX 21 at 57-59. In that document, Dr. Amos noted that "many months prior" to the claimant's last office visit, he had been started on a blinded pain cocktail and that during the period the claimant was receiving the blinded cocktail, the amount of narcotic medication in the cocktail had been intermittently increased and decreased without informing the claimant. Eventually, Dr. Amos noted, the claimant was "tapered off of narcotic pain medication." During the period the claimant received the blinded pain cocktail, Dr. Amos reported, "there did not appear to be any discernible correlation between the contents of the pain cocktail and the

² In this regard, it is noted that although Dr. Zietak assumed the practice of Dr. Amos, she never provided medical treatment to the claimant and is therefore not one of the claimant's treating physicians. Tr. II at 40-41.

patient's functional ability or pain complaints." It was also noted that the claimant frequently asked for narcotic pain medications such as Percocet and had refused to participate in the pain clinic program at the Virginia Mason Medical Center. In concluding the report, Dr. Amos indicated that she had recommended to the claimant that he cease taking narcotic medications and "taper off" his use of Soma. Dr. Amos also opined that the claimant had no permanent disability in his left shoulder or left forearm under the standards set forth in the fourth edition of the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, but noted that the claimant had a "category 2" impairment under a State of Washington impairment rating standard Dr. Amos referred to as "WAC 96-20-240."³ Finally, the report noted that from that date forward, the claimant would be receiving his medical treatment from Dr. Morris.

In March of 2001, the claimant returned to Dr. Morris for treatment of his various physical complaints. CX 23 at 157. He reported to Dr. Morris that his prescription for Percocet was not strong enough and Dr. Morris gave him a prescription for a stronger version of that medication. CX 23 at 157. During the same visit, Dr. Morris offered to get the claimant into a new physical therapy program, but the claimant declined the offer.

Thereafter, the claimant returned to Dr. Morris for treatment approximately once each month. CX 23, CX 18. During the claimant's April 2001 visit, Dr. Morris again increased the strength of the claimant's Percocet prescription. CX 23 at 154. On May 15, 2001, Dr. Morris examined the claimant, concluded that his condition was "stable" and indicated that "no further treatment" other than pain control would be undertaken. CX 23 at 151. In June of 2001, Dr. Morris increased the claimant's prescription for Paxil, an antidepressant medication. CX 23 at 148, 154. In July of 2001, the claimant reported to Dr. Morris that his pain was getting worse, but the following month he reported that he was "somewhat better." CX 23 at 141, 145. In September of 2001, the claimant told Dr. Morris that his pain had again worsened and Dr. Morris gave the claimant a prescription for a pain medication known as OxyContin. CX 23 at 138. However, the following month, Dr. Morris changed the claimant's pain medication back to Percocet. CX 23 at 132.

On September 28, 2001, the claimant was examined at the employer's request by Dr. Zietak. EX 17, EX 20. According to Dr. Zietak's report, the claimant told her that he had been in various physical therapy programs without achieving any improvement and that Dr. Amos had not done much for him, either. EX 17 at 2. The claimant also noted that he had ceased receiving psychotherapy as the result of a "mutual agreement" with Dr. Knowles, who he described as

³ There is apparently is no State of Washington impairment standard numbered "WAC 96-20-240." For this reason, it appears that Dr. Amos was probably referring to "WAC 296-20-240," which pertains to categories of cervical and cervicodorsal impairments. Category 2 of this provision applies to:

mild cervico-dorsal impairment, with objective clinical findings of such impairment with neck rigidity substantiated by x-ray findings of loss of anterior curve, without significant objective neurological findings. This and subsequent categories include the presence or absence of pain locally and/or radiating into an extremity or extremities. This and subsequent categories also include the presence or absence of reflex and/or sensory losses. This and subsequent categories also include objectively demonstrable herniation of a cervical intervertebral disc with or without discectomy or fusion, if present.

being “more of an actor” than a doctor. EX 17 at 2. When asked to describe his current symptoms, the claimant reportedly told Dr. Zietak that he had problems moving his left arm “in any way,” that he sometimes needed to wear elbow straps on both his left and right arms, that he had pain in his left shoulder, that he had constant pain in his neck and upper anterior chest wall, that his left knee was “sometimes terrible,” that he had had spasms in his right shoulder, and his pain sometimes kept him from sleeping for three or four days at a time. EX 17 at 3-4. According to Dr. Zietak’s description of her physical examination of the claimant, the claimant appeared to be “comfortable,” was able to raise both his arms overhead several times, gestured well with both arms, and was able to “easily” doff his T-shirt. EX 17 at 4. In addition, she reported, the muscle bulk on both of the claimant’s arms was within normal limits and there were no muscle spasms. EX 17 at 5. Nonetheless, the report indicates, the claimant complained of pain when there was “light surface palpitation,” made “ratchety and inconsistent” neck movements when his range of motion was tested, self-limited abduction of his right arm to 90 degrees, and displayed “giveaway” weakness when given formal strength tests of his arms and legs. EX 17 at 5. Dr. Zietak diagnosed the claimant’s medical condition as including “multiple somatic complaints with little in the way of objective findings,” and a “narcotic analgesic dependence.” EX 17 at 7. She concluded that no treatment was necessary for the claimant’s subjective complaints. She also noted that it is not unusual for patients with a prior history of substance abuse to use pain complaints in order to obtain narcotic analgesics. EX 17 at 7. For that reason, she suggested that the claimant might benefit from a referral to a chemical dependence facility. EX 17 at 7. Finally, she opined that the claimant is employable. EX 17 at 7.

On November 16, 2001, Dr. Morris send a letter to the claimant’s counsel concerning his treatment of the claimant. EX 22. In the letter, Dr. Morris described the claimant’s condition as consisting of “a chronic pain syndrome” and depression but indicated that he had “no opinion regarding whether his current condition is due to his work injury or not.” EX 22. Dr. Morris also commented that he does not believe that the claimant has a substance abuse problem and noted that the claimant had agreed not to obtain pain medication from any other physician. EX 22.

On December 11, 2001, Dr. Morris examined the claimant and reported that he had chronic problems attributable to back and neck pain, insomnia, and COPD secondary to smoking. CX 23 at 126. Dr. Morris also noted that the claimant is a “former alcoholic whose [sic] has not had a drink in 10 years,” and that he suffered from depression that Dr. Morris thought was largely “related to the narcotics” that the claimant had been taking on a chronic basis. CX 23 at 126. During that same visit, Dr. Morris decided to increase the claimant’s dose of a drug known as Neurontin in an attempt to decrease the claimant’s use of Percocet. CX 23 at 126.

In March of 2002, Dr. Morris examined the claimant and reported that he continued to have “chronic left shoulder, wrist, and elbow pain,” as well as occipital headaches and neck pain “at times.” CX 23 at 116.

On April 12, 2002, the claimant was examined by Dr. J. Brittin, an associate of Dr. Morris. CX 23 at 112. Dr. Brittin reported that his examination of the claimant indicated that

he had a reduced range of motion in his neck and that his neck flexion-extension ranged from 25 to 50 percent of normal. CX 23 at 112. Dr. Brittin also indicated that there was a spasm in the claimant's strap muscles and in his trapezius muscle. CX 23 at 112. According to Dr. Brittin's report, the spasms were relieved by injections of a mixture of lidocaine and Kenalog. CX 23 at 112. Ten days later, the claimant was examined by Dr. Morris, who reported that the claimant had regained nearly a full range of motion in his neck. CX 23 at 109.

In May of 2002, Dr. Morris reported that the claimant's condition had become "fixed and stable" and indicated that a physical examination had shown that the claimant had a limited range of motion in his right shoulder and cervical spine. CX 23 at 103. Dr. Morris also noted that the claimant was on "a drug compact" and that he was routinely taking prescriptions for Percocet, Neurontin, Paxil, and Soma. CX 23 at 103. The following month, Dr. Morris noted that at times the claimant had some severe muscle spasms in his neck and that this condition was being treated by prescribing Soma.

In September of 2002, Dr. Morris reported that the claimant continued to have "left-sided neck, shoulder, and elbow pain" and that a physical examination had shown a "very limited range of motion" in the claimant's cervical spine. CX 19 at 36. In addition, in November of 2002, Dr. Morris reported that the claimant was having so much left shoulder and elbow pain that his left arm was "almost unusable." CX 19 at 31. In December of 2002, Dr. Morris again examined the claimant and noted that the claimant was experiencing pain in his right arm and having pain in his knees when he walked. CX 19 at 26. The next month, Dr. Morris prepared a report indicating that the claimant was having muscle spasms in his neck and had chronic neck, shoulder, and elbow pain. CX 19 at 23. In February of 2003, the claimant told Dr. Morris that he was feeling a "terrible pain" in both his arms and also feeling pain under the right side of his rib cage. CX 19 at 20.

On March 24, 2003, the claimant was examined by Dr. Marco N. Wen, a physician employed in the Pain Management Center of Swedish Medical Center in Seattle. CX 20. In his report of the examination, Dr. Wen noted that the claimant had complaints of chronic pain that were "quite diffuse" and that the claimant felt that his chronic pain "holds him back from doing anything physical." CX 20 at 44. It was further noted that the claimant's pain complaints had not been helped by physical therapy, chiropractic manipulations, deep tissue massage, psychological counseling, or pain programs, but that trigger point injections had helped him. CX 20 at 44. Dr. Wen characterized the claimant's condition as including "chronic multifocal musculoskeletal pain" and "opioid dependence for pain." CX 20 at 45. The report lists several drugs that might be used as alternatives to the drugs prescribed by Dr. Morris, but notes that any final decisions would be made by Dr. Morris. CX 20 at 45.

On March 27, 2003, the claimant was re-examined by Dr. Zietak. EX 18. During the examination, the claimant told Dr. Zietak that Dr. Morris had continued to give him prescriptions for Neurontin, Paxil and Percocet, but that the prescription for a muscle relaxant (Soma) had been discontinued. EX 18 at 9. According to Dr. Zietak's report, the claimant also indicated that Dr. Wen had told him that he had too many things wrong with him to qualify for treatment at the Swedish Medical Center's Pain Management Center. EX 18 at 9. When asked to describe his

current complaints, the claimant told Dr. Zietak that during the past two months his pain levels had been “starting to accelerate” and that if he moved his arms down, he hurts from his shoulder to his elbows and forearms. EX 18 at 9. When Dr. Zietak conducted her physical examination of the claimant, she found that he was “less than cooperative” and that there were inconsistencies in the results of strength and range of motion tests. EX 18 at 9. She also noted that, although the claimant wore braces on both his elbows, he was able to “gesture well with both arms.” EX 18 at 9. In concluding her report, Dr. Zietak reiterated her earlier conclusions that the claimant had multiple somatic complaints that had little in the way of objective findings to support them and a narcotic analgesic dependence. EX 18 at 11. She also opined that no treatment was necessary for the claimant’s subjective complaints and that he was employable. EX 18 at 11.

ANALYSIS

The parties have disputes concerning two issues: (1) the date the claimant’s left arm condition reached the point of maximum medical improvement, and (2) whether the prior award of temporary total disability benefits should be modified.

1. Date of Maximum Medical Improvement

A disability is considered permanent on the date a claimant's condition reaches maximum medical improvement or if the condition has continued for a lengthy period of time and appears to be of lasting or indefinite duration. *Watson v. Gulf Stevedore Corp.*, 400 F.2d 649 (5th Cir. 1968), *cert. denied*, 394 U.S. 976 (1969); *Air America, Inc. v. Director, OWCP*, 597 F.2d 773, 781-82 (1st Cir. 1979); *Crum v. General Adjustment Bureau*, 738 F.2d 474, 480 (D.C. Cir. 1984); *Phillips v. Marine Concrete Structures, Inc.*, 21 BRBS 233 (1988). The issue of whether a claimant’s condition has reached the point of maximum medical improvement is primarily a question of fact and must be resolved on the basis of medical rather than economic evidence. *Williams v. General Dynamics Corp.*, 10 BRBS 915 (1979); *Ballesteros v. Willamette Western Corp.*, 20 BRBS 184 (1988); *Dixon v. John J. McMullen and Associates, Inc.*, 19 BRBS 243 (1986); *Trask v. Lockheed Shipbuilding and Construction Co.*, 17 BRBS 56 (1985). The mere possibility that a claimant's condition may improve in the future does not by itself support a finding that a claimant has not yet reached the point of maximum medical improvement. *Brown v. Bethlehem Steel Corp.*, 19 BRBS 200 (1987). However, a condition is not permanent as long as a worker is undergoing treatment that is reasonably calculated to improve the worker's condition, even if the treatment may ultimately be unsuccessful. *Abbott v. Louisiana Insurance Guaranty Ass'n*, 27 BRBS 192, 200 (1993), *aff'd sub. nom Louisiana Insurance Guaranty Ass'n v. Abbott*, 40 F.3d 122, 126 (5th Cir. 1994). An injury can be considered to have reached the point of maximum medical improvement on the date a physician rates the extent of an injured worker’s permanent disability, even if the physician does not explicitly opine that the condition has become permanent and stationary. *See Jones v. Genco, Inc.*, 21 BRBS 12, 15 (1988).

In considering medical evidence concerning a worker's injury, a treating physician's opinion is entitled to “special weight.” *Amos v. Director, OWCP*, 153 F.3d 1051 (9th Cir. 1998). In fact, in the Ninth Circuit clear and convincing reasons must be given for rejecting an *uncontroverted* opinion of a treating physician. *Magallanes v. Bowen*, 881 F.2d 747, 751 (9th

Cir. 1989). However, the Ninth Circuit has also held that a treating physician's opinion is not necessarily conclusive and may in some circumstances be disregarded, even if uncontradicted. For example, an administrative law judge may reject a treating physician's opinion that is "brief and conclusionary in form with little in the way of clinical findings to support [its] conclusion." *Id.* In addition, an administrative law judge can reject the opinion of a treating physician which conflicts with the opinion of an examining physician, if the ALJ's decision sets forth "specific, legitimate reasons for doing so that are based on substantial evidence in the record." *Id.*

In this case, the employer contends that the claimant's left arm impairments reached the point of maximum medical improvement on February 6, 2001, but the claimant contends that maximum medical improvement did not occur until May 15, 2001. The employer's contention is supported by the report of Dr. Amos, who concluded in her report of February 6, 2001 that the claimant had no ratable left shoulder or forearm impairment under the *AMA Guides* but did have a "category 2" impairment under a rating standard known as WAC 296-20-240. CX 21 at 57-59. In contrast, the claimant's contention that maximum medical improvement did not occur until May 15, 2001 is supported by the deposition testimony of Dr. Morris. CX 25 at 9. According to this testimony, Dr. Morris chose to find the claimant's condition had become stable on May 15, 2001 because there had been no improvement or deterioration in the claimant's condition after he "returned from the care of Dr. Amos."

After considering the foregoing evidence, it is concluded that the claimant's condition reached the point of maximum medical improvement on February 6, 2001. There are two reasons for this conclusion.

First, although Dr. Amos and Dr. Morris were both treating physicians, the opinion of Dr. Amos is entitled to greater weight because she specializes in treating the type of injuries suffered by the claimant and had been the primary treating physician for those injuries for nearly two years prior to February 6, 2001.

Second, Dr. Morris has not provided any testimony or other evidence that would indicate that the February 6, 2001 date of maximum medical improvement suggested by Dr. Amos was premature. Indeed, the fact that Dr. Morris acknowledged that there had been no change in the claimant's condition since he was released by Dr. Amos tends to indicate that the earlier date suggested by Dr. Amos is the more accurate date.

2. Modification of Prior Award of Temporary Total Disability Benefits

Both parties appear to agree that there has been a change in the claimant's medical condition and that the February 1, 2000 Decision and Order should therefore be modified. However, they disagree on the manner in which that Decision and Order should be changed. On one hand, the claimant contends that he is incapable of performing any type of employment and that the prior decision should therefore be modified to indicate that he is permanently and totally disabled. On the other hand, the employer argues that the claimant is no longer disabled by his June 19, 1997 work injury and that the Decision and Order must therefore be modified to indicate that he is no longer entitled to any wage loss benefits. Alternatively, the employer argues, the claimant is only partially, rather than totally, disabled by his work injury.

Under section 22 of the Act an administrative law judge may modify an otherwise final compensation order if there has been a change in conditions or a mistake of fact. 33 U.S.C. §922. If such a showing is made, a new compensation order issued under section 22 may terminate, continue, reinstate, increase, or decrease the amount of compensation. As well, the new compensation order may award compensation that had previously been denied. However, an award under section 22 may not change any compensation previously paid, except that an award increasing the compensation rate may be effective from the date of the claimant's work-related injury and an award decreasing the compensation rate may be effective from the date of the injury only to the extent that any part of the compensation due or to become due is unpaid. The reference to a "change in conditions" in section 22 encompasses changes in economic conditions as well as changes in a claimant's physical condition. *Metropolitan Stevedore Co. v. Rambo*, 515 U.S. 291 (1995). Thus, an employer may attempt to obtain modification of a total disability award by offering to establish that suitable alternative employment has become available to a claimant. *Blake v. Ceres, Inc.*, 19 BRBS 219 (1987). See also *Fleetwood v. Newport News Shipbuilding & Dry Dock Co.*, 776 F.2d 1225 (4th Cir. 1985). Any party seeking to have an award modified has the burden of showing that there has been a change of conditions or mistake of fact. See *Vasquez v. Continental Maritime of San Francisco, Inc.*, 23 BRBS 428 (1990).

It is well established that the same legal standards that apply when considering an initial application for Longshore Act benefits also apply in modification proceedings under section 22 of the Act. See *Vasquez v. Continental Maritime of San Francisco, Inc.*, 23 BRBS 428 (1990). Under these standards, an employee has the burden of showing that he or she is unable to return to his or her past job due to a work-related injury. If such a showing is made, the claimant is presumed to be totally disabled unless the employer is able to successfully demonstrate the existence of suitable alternative employment for the claimant in the geographical area where the claimant resides or was injured. See, e.g., *Bumble Bee Seafoods v. Director, Office of Workers' Compensation Programs*, 629 F.2d 1327 (9th Cir. 1980); *Hairston v. Todd Shipyards Corp.*, 849 F.2d 1194 (9th Cir. 1988). To satisfy its burden of showing the availability of suitable alternative employment, the employer must point to specific jobs that the claimant can perform. *Bumble Bee*, *supra*, at 1330. In considering whether a claimant has the ability to perform particular work, the fact finder must also consider the claimant's technical and verbal skills, as well as the likelihood that a person of the claimant's age, education, and background would be hired if he or she diligently sought the possible jobs identified by the employer. *Hairston*, *supra*, at 1196; *Stevens v. Director, OWCP*, 909 F.2d 1256 at 1258 (9th Cir. 1990). If an employer makes the requisite showing of suitable alternative employment, a claimant may rebut the employer's showing, and thus retain entitlement to total disability benefits, by demonstrating that he or she diligently tried to obtain such work, but was unsuccessful. *Edwards v. Director, OWCP*, 999 F.2d 1374, 1376 n.2 (9th Cir. 1993); *Palombo v. Director, OWCP*, 937 F.2d 70 (2nd Cir. 1991).

In this case, the claimant's contention that he is totally and permanently disabled is primarily supported by his own testimony and by the testimony and reports of Dr. Morris.

According to the claimant's testimony during the second trial (hereinafter cited as "Tr. II"), his left shoulder did not improve after the surgery performed by Dr. Scranton and he got no benefit from the psychological counseling he received from Dr. Knowles. Tr. II at 19, 21-22. He also testified that his symptoms have worsened since the first trial and that currently his main problems are a limited range of motion in his left shoulder and muscle spasms in his left shoulder and elbow. Tr. II at 23-25. These symptoms, he asserted, would make it impossible for him to climb ladders. Tr. II at 31. He also testified that his various medications sometimes cause him to become confused and that Dr. Morris told him his injuries preclude him from returning to work as a boilermaker. Tr. II at 27, 29. The claimant also testified that his job as a boilermaker required him to repeatedly climb ladders on ships and engage in "a lot of lifting." Tr. II at 16-17. On cross examination, the claimant acknowledged that each month he receives \$902 in Social Security benefits, \$1,300 from a boilermakers' pension, and more \$3,000 in Longshore Act benefits, but he denied that these payments collectively are more than he ever earned while working. Tr. II at 33-34.

According to the testimony of Dr. Morris, he believes that it is more probable than not that the "chronic pain" condition for which he has been treating the claimant stems from the injuries to the claimant's left shoulder and elbow. CX 25 at 7. He also testified that he examines the claimant approximately once each month and that during the examinations the claimant usually has limitations in the ranges of motion in his neck, left shoulder and left elbow, as well as tenderness in the elbow. CX 25 at 6-8. Dr. Morris also opined that the neck pain reported by the claimant is "probably secondary" to his left shoulder and arm injuries. CX 25 at 10. In addition, he testified, he has not noticed any signs of substance abuse by the claimant and does not believe that the claimant currently has a substance abuse problem. CX 25 at 14-15. Dr. Morris also testified that the claimant's condition has not improved since 1998 and may have even worsened. CX 25 at 17. Further, he opined, the limitations in the claimant's use of his left arm and shoulder preclude him from returning to work as a boilermaker. CX 25 at 17-18. Moreover, he testified, he does not believe the claimant is capable of performing any the various alternative jobs identified in the employer's labor market survey. CX 25 at 18-19. However, Dr. Morris admitted that he is not sure what effect there has been from the claimant's long-term use of narcotic medications and acknowledged that he has not instructed the claimant to use the arm braces and supports that he sometimes wears. CX 25 at 9, 11. Dr. Morris also testified that at this time the claimant uses the muscle relaxing drug Soma only occasionally.

During cross-examination, Dr. Morris conceded that Dr. Valpey could find no abnormalities when he performed nerve conduction studies on the claimant's left upper extremity in 1999 and that Dr. Wright found the claimant's neck to be in reasonably normal condition. CX 25 at 20, 21. When asked about Dr. Scranton's report that his examination of the claimant produced a number of "Waddell's signs," Dr. Morris admitted that he does "not know what a Waddell's sign is." CX 25 at 22. Dr. Morris also acknowledged that there is a "certain degree of what we call functional overlay" in the claimant's behavior and described a functional complaint as being a pain complaint that exceeds what might be expected from looking at "the physical picture." CX 25 at 23. He also testified that functional complaints are usually ascribed to "psychiatric difficulties" but acknowledged that they can also be due to a desire for some sort of personal gain. CX 25 at 24. In addition, Dr. Morris admitted that Dr. Scranton had questioned the claimant's veracity and testified that Dr. Scranton thinks the claimant is "lying"

when he says his shoulder is not getting any better. CX 25 at 24. Dr. Morris also conceded that his measurements of the claimant's range of motion depend on the claimant's willingness to give him "straight information" and acknowledged that his opinion concerning the claimant's ability to sit or stand is solely based on what the claimant tells him. CX 25 at 26, 30. In addition, he testified that he has not referred the claimant to any mental health professionals because "his mental health seemed to be stable in the last several years." CX 25 at 28.

The employer's contention that the claimant is able to return to work as a boilermaker is primarily supported by the February 6, 2000 report of Dr. Amos⁴ and by the reports and trial testimony of Dr. Zietak. In brief, Dr. Zietak testified that she found the same results in both of her physical examinations of the claimant and that these results indicate that the claimant had many pain complaints that cannot be explained. Tr. II at 53. More specifically she testified, the claimant's pain complaints were "not reliable" and there were "many inconsistencies" in the claimant's presentation during those physical examinations. Tr. II at 63. Dr. Zietak concurred with Dr. Scranton's opinion that there was a good outcome from the surgery he performed on the claimant's shoulder. Tr. II at 55. Dr. Zietak also agreed with the decision by Dr. Amos to withdraw the claimant from his narcotic medications and with her finding that the claimant did not have any permanent disability in his left arm and shoulder. Tr. II at 59, 62. Likewise, Dr. Zietak also testified that the claimant's neck complaints do not warrant any sort of work limitations and opined that the claimant can return to the type of work he was performing at the time of his injury or, alternatively, perform any of the other jobs identified by the employer's vocational expert. Tr. II at 69, 71. In explaining her concurrence with Dr. Amos's decision to terminate the claimant's use of narcotic medications, Dr. Zietak noted that the claimant had not been given any narcotic medications during the first six months after his work injury and asserted that, except for a period around the time of the claimant's shoulder surgery, there was "no rhyme or reason for him to be placed" on such medications at such a late date. Tr. II at 58. She further testified that the claimant's medical records show that the narcotic medications he has been taking do not lessen his alleged pain, but do indicate that the claimant appears to have a dependence on narcotic medications. Tr. II at 61. However, she testified, the claimant's continued use of such medications would not preclude him from driving or from going to work. Tr. II at 60. She also opined that because the claimant has "no objective findings," he has no need for any on-going medical care. Tr. II at 59. Dr. Zietak further noted that although Dr. Morris is a specialist in family medicine, he is not a specialist in treating chronic pain and suggested that perhaps this lack of specialized experience could explain why Dr. Morris is not familiar with Waddell's signs. Tr. II at 64-65. Such signs, she testified, are used by pain specialists to determine if a patient's pain complaints are organic or attributable to some other cause. Tr. II at 64-65. However, during cross-examination Dr. Zietak conceded that Dr. Wen at the Swedish Pain Clinic did not recommend discontinuing the claimant's narcotic medications and that physicians at the Virginia Mason pain management center characterized the claimant as having a history of symptoms of epicondylitis, degenerative disc disease at three levels in his neck, surgery to repair a torn rotator cuff, and depression. Tr. II at 73-75. As well, Dr. Zietak agreed that pain is often subjective and cannot be measured by any objective standard. Tr. II at 78. She also conceded that she could not list the duties of a boilermaker. Tr. II at 81.

⁴ As previously noted, the February 6, 2001 report of Dr. Amos concluded that the claimant's left shoulder and arm injuries did not cause any impairment ratable under the AMA *Guide* but did result in an impairment under a State of Washington impairment standard known as WAC 296-20-240.

After consideration of all the relevant evidence, it has been determined that the opinions of Dr. Amos and Dr. Zietak concerning the claimant's ability to work are more convincing than the contrary opinion of Dr. Morris. Accordingly, it has been determined further that the claimant's entitlement to wage loss benefits ceased on February 6, 2001—the date his condition reached the point of maximum medical improvement. There are three reasons for these conclusions.

First, although Dr. Morris is one of the claimant's treating physicians, his opinions concerning the claimant's alleged impairments have been contradicted by other physicians who have greater expertise in the treatment of orthopedic injuries and chronic pain. Most significantly in this regard, the opinions of Dr. Morris have been directly contradicted by Dr. Amos, who is a specialist in the treatment of chronic pain and was the claimant's treating physician for almost two years. For example, the opinion of Dr. Morris concerning the claimant's continuing need for narcotic pain medications directly conflicts with the findings of Dr. Amos, who concluded that the claimant should no longer be given such pain medications because his behavior during the period he received the blinded pain cocktail indicated that there was no discernable correlation between the contents of the pain cocktail and the claimant's functional ability or pain complaints. Likewise, the opinion of Dr. Morris concerning the claimant's limitations is also inconsistent with the conclusion by Dr. Amos that the claimant had no left arm or shoulder impairment under the fourth edition of the *AMA Guides*. In addition, the opinion of Dr. Morris concerning the claimant's ability to work has also been directly contradicted by the opinion of Dr. Zietak, who has spent many years specializing in the treatment of chronic pain. The opinion of Dr. Morris is also entitled to less weight because he admitted that he essentially takes the claimant's representations at face value when determining the claimant's work limitations and has acknowledged that he is unfamiliar with the "Waddell's signs" of non-organic pain complaints.

Second, there is ample evidence in the record that many of the claimant's complaints do not have an organic basis and are therefore unlikely to accurately reflect his true ability to work. For example, at least five physicians have noted that the claimant either refused to fully cooperate in physical examinations, made pain complaints that apparently lacked an organic basis, or engaged in inconsistent behavior during an examination. *See* CX 21 at 68 (report of Dr. Amos indicating that on August 8, 2000 the claimant displayed a greater range of motion when reciting his medical history than when being physically examined), CX 11 at 143 (report of Dr. McCollum indicating that the claimant did not provide "maximum cooperation" during a June 30, 1999 physical examination and that the claimant's physical examination had resulted in "bizarre physical findings"), CX 22 at 86-87 (report of Dr. Scranton indicating that his March 22, 2000 examination of the claimant revealed "a number of Waddell's signs" and that, as a result, he "could not get an accurate assessment" of the claimant's rotator cuff function), CX 22 at 93 (report of Dr. Stanton indicating that he doubted the veracity of the claimant's assertion that his left shoulder had worsened and noting that the claimant was "exhibiting more and more functional behavior"), EX 17 (September 28, 2000 report of Dr. Zietak indicating that the claimant made "ratchety and inconsistent" neck movements during range-of-motion testing), EX 18 (report of Dr. Zietak indicating that when she examined the claimant on March 27, 2003, he

was “less than cooperative” and that there were inconsistencies in the results of strength and range of motion tests). Indeed, even Dr. Morris has conceded that there is a “certain degree of what we call functional overlay” in the claimant’s behavior and described a functional complaint as being a pain complaint that exceeds what might be expected from looking at “the physical picture.” CX 25 at 23. It therefore appears that the claimant may well be exaggerating the extent of any impairments for the purpose of securing continued access to narcotic medications, prolonging the payment of wage loss benefits under the Longshore Act, or both. In any event, the claimant’s continuous exaggeration of his alleged impairments makes it impossible to draw any reliable conclusions about the true extent of his actual impairments.

Third, although there is some evidence that the claimant has depression and some mild medical abnormalities in his neck, there is no convincing evidence that either of these conditions would preclude him from returning to work. Indeed, Dr. Amos apparently concluded that the claimant’s neck condition was not even significant enough to warrant a disability rating under the *AMA Guides*. CX 21 at 57-59. Moreover, Dr. Wright’s review of the claimant’s medical tests indicates that the MRI scan of the claimant’s cervical spine showed only “unremarkable” results and that the results of the claimant’s EMG testing were inconsistent with such possible conditions as brachial plexopathy, stretch injuries, or entrapment neuropathies. CX 15 at 159b. Although the medical records do indicate that the claimant experienced muscle spasms in his neck on as many as three occasions in 2002, the records also show that this condition was promptly and successfully treated by injections and prescriptions for the muscle-relaxant Soma. CX 23 at 109, 112. Moreover, the evidence indicates that by March of 2003 even Dr. Morris had decided that the claimant no longer needs to take Soma on a continuous basis. CX 25 at 11. Likewise, the non-disabling nature of the mild depression diagnosed by Dr. Morris is illustrated by the fact that the claimant voluntarily ended his psychotherapy sessions with Dr. Knowles and by the fact that Dr. Morris has not found it necessary to either increase the claimant’s antidepressant medication or refer the claimant to a psychiatrist for more specialized treatment.

ORDER

1. The Decision and Order issued on February 1, 2000 is hereby modified to provide that the claimant's entitlement to temporary total disability benefits ended on February 5, 2001 and that since February 6, 2001 he has no longer been entitled to receive any sort of wage loss disability benefits.

2. Pursuant to the provisions of section 22 of the Act, the employer is entitled to deduct from any future disability payments that may be owed to the claimant an amount equal to the amount found herein to have been overpaid between February 6, 2001 and the service date of this Order. As required under the provisions of section 22, the manner and method for taking such deductions shall be determined by the District Director.

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Paul A. Mapes
Administrative Law Judge